Mercer Internal Medicine LLC

MDVIP Wellness Assessment Screening Forms

Please complete the following health screening forms. Many of the questions may seem silly or irrelevant. Just respond to the questions the best you can. These studies really do help us to better understand your condition and how we can best be of service to you.

Your answers will remain completely confidential as part of your private medical record. If you do not feel comfortable answering any of the questions, just say so on the form or simply leave the response area blank.

Please mail the completed health screening forms to us or bring them in when you meet with the nurse for part 1 of the wellness assessment when the pre-physical testing is done.

Please do not eat or drink anything other than water on the morning of the pre-physical testing visit since fasting blood work will be drawn. Light snacks, coffee, tea, and juice will be available for you in the waiting room once the blood specimen is drawn. You do not need to fast for the part 2 visit when you meet with the doctor.

Following are your MDVIP Wellness Assessment appointment times:

Part 1 Pre-Physical testing after an 8-12 hour overnight fast (water okay):

Mon Tue Wed Thu Fri _____ / _____ / _____ at _____ : _____ a.m. / p.m.

Don't forget to bring or send the completed health screening forms.

Part 2 Physical examination and review of test findings with the doctor:

Mon Tue Wed Thu Fri _____ / _____ / _____ at_____ : _____ a.m. / p.m.

Thanks!

MIM Nutritional Assessment Ver. 5 **Name:**________________________ **Date:**________

In the course of the last few months, was your diet characterized by: *Circle your responses*

eating regular meals (breakfast, lunch, and dinner) rather than skipping meals?
0 - Rarely 1 - Sometimes 2 - Usually

eating until satisfied without overeating?
0 - Rarely 1 - Sometimes 2 - Usually

choosing nutritious snacks instead of unhealthy "junk" foods?
0 - Rarely 1 - Sometimes 2 - Usually

eating whole grains (whole grain cereal, whole wheat bread, and brown rice) instead of processed refined grains (white bread and white rice)?
0 - Rarely 1 - Sometimes 2 - Usually

one or more vegetable or salad servings per day?
0 - Rarely 1 - Sometimes 2 - Usually

one or more fruits per day?
0 - Rarely 1 - Sometimes 2 - Usually

use of nonfat or low-fat dairy products (2% or less) instead of regular fat dairy products?
0 - Rarely 1 - Sometimes 2 - Usually

no more than one serving a week of deep fried or other high saturated fat foods (french fries/fried chicken/hamburgers)?
0 - Rarely 1 - Sometimes 2 - Usually

2 or more servings of fish per week (not deep fried)?
0 - Rarely 1 - Sometimes 2 - Usually

3 or less servings of red meat per week?
0 - Rarely 1 - Sometimes 2 - Usually

use of olive or canola oil instead of butter, margarine, or shortening?
0 - Rarely 1 - Sometimes 2 - Usually

avoidance of sugary foods and drinks?
0 - Rarely 1 - Sometimes 2 - Usually

avoidance of salty snack foods or use of the salt shaker on food at the table?
0 - Rarely 1 - Sometimes 2 - Usually

drinking enough fluids to keep the urine dilute?
0 - Rarely 1 - Sometimes 2 - Usually

Total Score:________ *Maximum score is 28.*

Epworth Sleepiness Scale

Name: ______________________________

Date: ______________________________

Your age: (Yr) ________________ Your sex: ☐ Male ☐ Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:-

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	Chance of dozing
Sitting and reading	☐
Watching TV	☐
Sitting, inactive in a public place (e.g. a theatre or a meeting)	☐
As a passenger in a car for an hour without a break	☐
Lying down to rest in the afternoon when circumstances permit	☐
Sitting and talking to someone	☐
Sitting quietly after a lunch without alcohol	☐
In a car, while stopped for a few minutes in the traffic	☐
Total	☐

THE BURNS DEPRESSION CHECKLIST*

Instructions:
The following is a list of symptoms that people sometimes have. Select the appropriate box that best describes how much you experienced the symptom during the past week.

		0 - None at All	1 - Somewhat	2 - Moderately	3 - A Lot	4 - Extremely
	Thoughts and Feelings					
1.	Feeling sad or down in the dumps					
2.	Feeling unhappy or blue					
3.	Crying spells or tearfulness					
4.	Feeling discouraged					
5.	Feeling hopeless					
6.	Low self-esteem					
7.	Feeling worthless or inadequate					
8.	Guilt or shame					
9.	Criticizing yourself or blaming yourself					
10.	Difficulty making decisions					
	Activities and Personal Relationships					
11.	Loss of interest in family, friends or colleagues					
12.	Loneliness					
13.	Spending less time with family or friends					
14.	Loss of motivation					
15.	Loss of interest in work or other activities					
16.	Avoiding work or other activities					
17.	Loss of pleasure or satisfaction in life					
	Physical Symptoms					
18.	Feeling tired					
19.	Difficulty sleeping or sleeping too much					
20.	Decreased or increased appetite					
21.	Loss of interest in sex					
22.	Worrying about your health					
	Suicidal Urges**					
23.	Do you have any suicidal thoughts?					
24.	Would you like to end your life?					
25.	Do you have a plan for harming yourself?					

[Calculate Total] [Reset] **Total score:** / 100

* Copyright 1984 David M. Burns, M.D. (Revised, 1996)

** Anyone with suicidal urges should seek help from a mental health professional

Interpreting the Burns Depression Checklist:

Total Score:	*Level of Depression:*
0-5	no depression
6-10	normal but unhappy
11-25	mild depression
26-50	moderate depression
51-75	severe depression
76-100	extreme depression

NAME ______________________ DATE ______________________

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	NOT AT ALL	MILDLY It did not bother me much.	MODERATELY It was very unpleasant, but I could stand it.	SEVERELY I could barely stand it.
1. Numbness or tingling.				
2. Feeling hot.				
3. Wobbliness in legs.				
4. Unable to relax.				
5. Fear of the worst happening.				
6. Dizzy or lightheaded.				
7. Heart pounding or racing.				
8. Unsteady.				
9. Terrified.				
10. Nervous.				
11. Feelings of choking.				
12. Hands trembling.				
13. Shaky.				
14. Fear of losing control.				
15. Difficulty breathing.				
16. Fear of dying.				
17. Scared.				
18. Indigestion or discomfort in abdomen.				
19. Faint.				
20. Face flushed.				
21. Sweating (not due to heat).				

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Beck Anxiety scoring

Score:

0= Not at all

1= Mildly

2= Moderately

3= Severely

Maximum score = 63 points

0-7 – Minimal Anxiety

8-15 –Mild Anxiety

16-2 – Moderate Anxiety

26-63 Severe Anxiety

Duke Activity Status Index

Overview:

The Duke Activity Status Index is a self-administered questionnaire that measures a patient's functional capacity. It can be used to get a rough estimate of a patient's peak oxygen uptake.

Item	Activity	Yes	No
1	Can you take care of yourself (eating dressing bathing or using the toilet)?	2.75	0
2	Can you walk indoors such as around your house?	1.75	0
3	Can you walk a block or two on level ground?	2.75	0
4	Can you climb a flight of stairs or walk up a hill?	5.50	0
5	Can you run a short distance?	8.00	0
6	Can you do light work around the house like dusting or washing dishes?	2.70	0
7	Can you do moderate work around the house like vacuuming sweeping floors or carrying in groceries?	3.50	0
8	Can you do heavy work around the house like scrubbing floors or lifting and moving heavy furniture?	8.00	0
9	Can you do yardwork like raking leaves weeding or pushing a power mower?	4.50	0
10	Can you have sexual relations?	5.25	0
11	Can you participate in moderate recreational activities like golf bowling dancing doubles tennis or throwing a baseball or football?	6.00	0
12	Can you participate in strenuous sports like swimming singles tennis football basketball or skiing?	7.50	0

Duke activity status index =

= SUM(values for all 12 questions)

Interpretation:

- maximum value 58.2
- minimum value 0

estimated peak oxygen uptake in mL/min =

= (0.43 * (duke activity status index)) + 9.6

References:

Hltaky MA Boineau RE et al. A brief self-administered questionnaire to determine functional capacity (The Duke Activity Status Index). Am J Cardio. 1989; 64: 651-654

MIM Sexual Satisfaction Questionnaire Ver. 2 **Name:**______________________________ **Date:**___________

Please note that your responses in this questionnaire are completely confidential. We are not trying to pry into your private life. We are trying to find ways we can better understand your situation and help you live a more fulfilling life. You do not have to answer any questions you feel uncomfortable responding to.

Are you satisfied with your sexual life?

☐ Yes, I am satisfied with my sexual life. If you answered yes, you are done with this survey! Don't bother with the rest of the questions.
☐ Somewhat. However, there are things in my sexual life that I wish were better.
☐ No. I am unsatisfied with my sexual life.

Are you satisfied with your level of sexual desire?

☐ Yes, I am content with the level of my sexual desire.
☐ Yes, I am content with my own level of sexual desire but there is a problem because it is not compatible with my partner's level of sexual desire.
☐ Sometimes
☐ No, I wish I had more interest in sex.
☐ No, I wish I had less interest in sex.

Are you generally satisfied with the frequency of your sexual experiences?(you may choose more than one option)

☐ Yes. I usually feel that I get enough sexual experiences to feel content.
☐ Occasionally
☐ No or rarely. I wish I had more opportunities to express myself sexually.
☐ I wish I had a partner with whom I could develop a fulfilling sexual relationship.
☐ I feel too shy or self conscious to initiate sex with my partner

For women only: Sometimes, sexual experiences are not as satisfying as I wish because... (you may choose more than one option)

☐ there is not enough lubrication to feel comfortable.
☐ there is an element of pain (emotional or physical) during sex that is not just due to dryness.
☐ it is so difficult for me to reach an orgasm.
☐ I do not feel as close or attracted to my partner as I would like.
☐ my partner has difficulties with their own sexual functioning.
☐ Other: ____

For men only: Sometimes, sexual experiences are not as satisfying as I wish because... (you may choose more than one option)

☐ there are times when it is difficult for me to get or maintain an erection. If this is checked, please complete the Sexual Health Inventory for Men (SHIM) on the next page.
☐ there is an element of pain (emotional or physical) during sex.
☐ I reach an orgasm so quickly that the sexual experience is compromised.
☐ it is so difficult for me to reach an orgasm.
☐ I do not feel as close or attracted to my partner as I would like.
☐ my partner has difficulties with their own sexual functioning.
☐ Other: ____

Men should complete this form if there is any history of erectile dysfunction.

Sexual Health Inventory for Men (SHIM)

Patient's Name: ______________________________

Physician's Name: ______________________________ Date: ______________

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for **each question**.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?		Very Low	Low	Moderate	High	Very High
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	No Sexual Activity	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion or intercourse?	Did Not Attempt Intercourse	Extremely Difficult	Very Difficult	Difficult	Slight Difficult	Not Difficult
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5

Add the numbers corresponding to questions 1-5. TOTAL: ______

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED
8-11 Moderate ED
12-16 Mild to Moderate ED
17-21 Mild ED

Have you tried any medications to help with erections (Viagra, Levitra, or Cialis)? Yes No

Have these medications helped with erections? Yes No Not applicable

Rapid Assessment of Physical Activity

Physical Activities are activities where you move and increase your heart rate above its resting rate, whether you do them for pleasure, work, or transportation.

The following questions ask about the amount and intensity of physical activity you usually do. The intensity of the activity is related to the amount of energy you use to do these activities.

Examples of physical activity intensity levels:

Intensity	Examples
Light activities • your heart beats slightly faster than normal • you can talk and sing	Walking Leisurely; Stretching; Vacuuming or Light Yard Work
Moderate activities • your heart beats faster than normal • you can talk but not sing	Fast Walking; Aerobics Class; Strength Training; Swimming Gently
Vigorous activities • your heart rate increases a lot • you can't talk or your talking is broken up by large breaths	Stair Machine; Jogging or Running; Tennis, Racquetball, Pickleball or Badminton

How physically active are you? *(Check one answer on each line)*

		Does this accurately describe you?	
		Yes	No
RAPA 1 — 1	I rarely or never do any physical activities.	☐	☐
2	I do some **light** or **moderate** physical activities, but not every week.	☐	☐
3	I do some **light** physical activity every week.	☐	☐
4	I do **moderate** physical activities every week, but less than 30 minutes a day or 5 days a week.	☐	☐
5	I do **vigorous** physical activities every week, but less than 20 minutes a day or 3 days a week.	☐	☐
6	I do 30 minutes or more a day of **moderate** physical activities, 5 or more days a week.	☐	☐
7	I do 20 minutes or more a day of **vigorous** physical activities, 3 or more days a week.	☐	☐
RAPA 2 (3 = Both 1 & 2) — 1	I do activities to increase muscle **strength**, such as lifting weights or calisthenics, once a week or more.	☐	☐
2	I do activities to improve **flexibility**, such as stretching or yoga, once a week or more.	☐	☐

ID # ______________________

Today's Date ______________________

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Print out this form to complete. Mail, fax, or bring the completed form to the office.

If you have recently completed a medical history form like this, it is fine with us if you just update any changes since your last documentation. We know it is a lot of work to complete forms like this, but it really helps us to give you the best of care when we have your full medical history.

Name:____ **Age:**______ **Today's date:**_________

Current medical concerns and symptoms (if this is for your MDVIP Wellness Assessment, this section may be left blank):

____

____

____

____

____

Previous surgeries and hospitalizations (include dates or year if known): ____________________

____

____

____

____

____

____

Previous colon cancer screening with colonoscopy or barium enema?   Yes   No   If yes, year done:_______

Name of GI specialist:____

Circle or list previously diagnosed medical illnesses:

Hypertension	Diabetes
High cholesterol	Hypothyroidism/Hyperthyroidism/Goiter
Glaucoma/Cataract	Coronary disease/Heart attack
Congestive heart failure	Valvular heart disease
Cardiac arrhythmia	Emphysema/Chronic bronchitis
Asthma/Hayfever/Eczema	Peptic ulcers(duodenal/gastric)
GERD/reflux/acid indigestion	Hepatitis (type if known)________________________
Stroke	Seizures
Anemia	Bleeding disorder
Clots in legs/lungs (DVT/PE)	Cancer
HIV/AIDS	Tuberculosis
Obesity/Eating disorder	Other illnesses:______________________________

Current medications (including birth control pills and non-prescription drugs): __________________

____

____

____

____

____

Drug and Food Allergies: ____

Immunizations received: Tetanus(most recent) _______ Influenza(most recent) ________

Pneumovax_______ Other immunizations: ____

Do you use eyeglasses or contact lenses? Do you use eyeglasses or contact lenses? Yes No

Eye doctor's name:____

Do you use hearing aides? Yes No

Family History

Have any of your close family members suffered from hypertension, diabetes, heart attacks, stroke, cancer, or tuberculosis? If so, please indicate details of the family medical history below:

Paternal Grandfather (your father's dad): ______________________________

Alive? Yes No, If no, age and cause of death: ______________________________

Paternal Grandmother (your father's mom): ______________________________

Alive? Yes No, If no, age and cause of death: ______________________________

Maternal Grandfather (your mother's dad): ______________________________

Alive? Yes No, If no, age and cause of death: ______________________________

Maternal Grandmother (your mother's mom): ______________________________

Alive? Yes No, If no, age and cause of death: ______________________________

Father: ______________________________

Alive? Yes No, If no, age and cause of death: ______________________________

Mother: ______________________________

Alive? Yes No, If no, age and cause of death: ______________________________

Brother #1: ______________________________

Alive? Yes No, If no, age and cause of death: ______________________________

Brother #2: ______________________________

Alive? Yes No, If no, age and cause of death: ______________________________

Sister #1: ______________________________

Alive? Yes No, If no, age and cause of death: ______________________________

Sister #2: ______________________________

Alive? Yes No, If no, age and cause of death: ______________________________

Son/daughter #1: ______________________________

Alive? Yes No, If no, age and cause of death: ______________________________

Son/daughter #2: ______________________________

Alive? Yes No, If no, age and cause of death: ______________________________

Son/daughter #3: ______________________________

Alive? Yes No, If no, age and cause of death: ______________________________

Social History

Place of birth: _______________ **Places where you were raised**: ____________________

Marital status: Single Married Divorced Widowed Separated Unmarried but in a relationship

Ages of children (if any): _____ _____ _____ _____ _____ _____ _____ _____

Occupation and place of work: ____

____

Special interests/hobbies: ____

____

Do you smoke? Yes (average # of packs per day:____ starting age____). Never smoked. Previously smoked but quit in____

Do you drink alcohol? Yes, average # of drinks per week:___. Never or rarely drink.

Do you usually wear your seat belt when in a car? Yes No

Are you at risk for sexually transmitted illnesses? Yes No Not sure Interested in getting tested

Do you have an exercise regimen to help stay physically fit? Yes No If yes, please briefly describe your routine:

____

Are you on any special type of diet? Yes No If yes, please briefly describe the type of diet:

____

Do you have an Advance Directive/Living Will? Yes No

Hand dominance: Right handed Left handed Ambidextrous

For men only:

When was your last PSA blood test done? ____________________

For women only:

Last Pap smear: _________________

Last mammogram: __________________

Last DEXA bone density study:_________________

Number of pregnancies: ____________ Number of live deliveries:__________

Birth control method:_____________ Last menstrual period:____________

Irregular or heavy periods? ______________ Painful periods?_________________

Age when periods started:____________ Age when first child was born:_________________

If post menopausal, age at menopause: _________ Name of gynecologist:_____________________

Review of Systems

Have you recently had any of the following symptoms? Please circle those symptoms which pertain to you. In the space on the page, please try to describe the location, duration, and severity of the symptom as well as the circumstances under which the problem seems to occur.

Weight loss/weight gain	Fatigue/weakness
Fever/night sweats	Exercise intolerance
Visual disturbance	Hearing loss/ringing in ears
Nasal congestion/sinus pain	Nose bleed
Throat pain/hoarseness	Swelling in the neck
Breast pain/lump/nipple discharge	Chest pain/palpitations
Cough/sputum	Shortness of breath/wheezing
Abdominal pain/heartburn	Nausea/vomiting/diarrhea
Bloody or black tarry bowel movements	Pain on urination/blood in urine
Difficulty starting or maintaining urine flow	Involuntary leakage of urine
Unusually frequent urination	Discharge from penis or vagina
Concerns about sexual functioning	Joint pain/stiffness
Backache/muscle pain	Cold feet/hands
Cramps in legs with walking	Leg/ankle swelling
Rash/itching	Lumps/bumps/change in mole
Headache/dizziness	Fainting/blackouts
Numbness	Tremors
Confusion/memory difficulties	Localized weakness/paralysis
Nervousness/depression	Insomnia
Heat or cold intolerance	Excessive sweating
Excessive thirst, hunger, or urination	Easy bruising or bleeding
Swollen lymph nodes/glands	

Thanks for completing the Medical History Form! That was a lot of work!!

Mercer Internal Medicine, LLC Reviewed by: *GN* *MY*